Experiences and perceptions of dietitians for obesity management

Abbott, Sally; Parretti, Helen; Greenfield, Sheila

DOI:
10.1111/jhn.12855

Document Version
Peer reviewed version

Citation for published version (Harvard):
Abbott, S, Parretti, H & Greenfield, S 2021, 'Experiences and perceptions of dietitians for obesity management: a general practice qualitative study', *Journal of Human Nutrition and Dietetics*, vol. 34, no. 3, pp. 494-503. https://doi.org/10.1111/jhn.12855

Table S1: Topic guide used for semi-structured interviews with general practice healthcare professionals

Questions
1. Do you have a dietitian working within your general practice?
2. What do you think is the role of dietitians in the context of obesity?
3. Have you ever referred a patient to a dietitian for obesity management? If yes, tell me about your experience. If no, why do you think this is?
4. If a dietitian worked within your general practice team, to what extent do you think they would be useful?
5. If a dietitian worked within your general practice team, do you think would this influence obesity assessment? If yes, how? If no, why not?
6. If a dietitian worked within your general practice team, do you think this would influence obesity management? If yes, how? If no, why not?
7. If a dietitian worked with your general practice team, what would encourage you to refer a patient with obesity to them?
8. If a dietitian worked with your primary care team, what would prevent you referring a patient with obesity to them?

Table 1: Participants' demographics and employing GP practices' patient population demographics

Participant	Individual				GP practice			
	Profession	Gender	Experience (years)	Position	Size of practice*	Deprivation level (IMD 2019)	Non-white ethnicity (%)	Location
GP1	GP	Male	20	Salaried	Small	11.6	2.6	Rural
GP2	GP	Female	14	Locum	**	**	**	**
GP3	GP	Female	20	Partner	Large	32.5	16.5	Urban
GP4	GP	Female	12	Locum	Large	17.7	24.6	Urban
GP5	GP	Female	9	Partner	Small	12.2	8.8	Urban
GP6	GP	Female	19	Partner	Large	33.8	23.9	Urban
GP7	GP	Female	11	Partner	Small	***	***	Rural
GP8	GP	Male	4	Salaried	Large	23.5	7.8	Urban
GP9	GP	Female	14	Partner	Large	21.8	1.7	Urban
GPN1	GPN	Female	28	GPN Manager	Large	17.4	14.5	Urban
GPN2	GPN	Female	30	GPN Manager	Large	17.7	6.8	Urban
GPN3	GPN	Female	18	GPN Manager	Small	33.7	3.8	Urban
GPN4	GPN	Female	5	GPN Manager	Large	7.8	2.6	Rural
GPN5	GPN	Female	3	GPN	Small	33.7	1.5	Urban
GPN6	GPN	Female	13	ANP	Large	28.4	5.5	Urban
GPN7	GPN	Female	24	ANP	Large	50.8	61.1	Urban
GPN8	GPN	Female	7	GPN	****	****	****	Rural
GPN9	GPN	Female	17	GPN Educator	Small	15.1	4.9	Urban
GPN10	GPN	Female	29	GPN	Large	18.5	2.5	Urban
GPN11	GPN	Female	19	ANP	Large	6.8	3.9	Urban
Summary	9 GPs 11 GPNs	2 Males 18 Females	Mean 16 (range 3 – 30)	GPs: 2 salaried, 2 locum, 5 partners GPNs: 3 GPNs, 3 ANPs, 4 GPN managers, 1 GPN educator	6 Small 12 Large	Mean 21.3 (range 6.8 – 50.8)	Mean 11.4 (range 1.5 – 61.1)	4 Rural 15 Urban

GP, general practitioner; GPN, general practice nurse; ANP, advanced nurse practitioner

* small practices = <6000 registered patients and large practices = ≥6000 registered patients, ** Locum at >1 GP practice, *** Data not available for Scotland, **** Data not available for military GP practices

Table 2: Illustrative quotes from general practice healthcare professionals regarding their experiences of referring patients to dietitians for obesity management

Themes and Sub-themes	Participant Quotations
1. Barriers to access	
1a. Geographical disparity	"…and if people want advice on weight reduction, we can refer them to a dietitian quite easily in our area, but I appreciate that isn't always available in every sort of, every area of the country." (GP5) "INT: In your experience, how would you describe referring a patient to a dietitian for obesity?" Impossible… It's just that there's no, there's just no service available… patients have asked, "Can I be referred to a dietitian?" and I have to say, "Actually they're not available." (GPN3)
1b. Rejected referrals	"There are some patients which are not quite heavy enough, but you feel that they need perhaps a little bit more intensive input." (GP6) "I have done referrals to different, you know, dietitian services within the area and it's been declined, depending on the long term conditions and things that they've got… it just comes back and says they don't meet the criteria. And unless you have the time to actually then write another letter saying, "Well can you tell me why they didn't meet the criteria?", normally you don't tend to because, you know, doing it within clinical hours, it sometimes can be a bit hard." (GPN5)
1c. Referral criteria	"…we can refer, but I know the service is so oversubscribed, that as far as I know, they don't just accept referrals for obese patients… they're very, very short, that we can really only refer patients that we're struggling with, not necessarily just the obese patients, but you know, others with dietary needs as well." (GPN10) "…you refer in the underweight [to dietitians], when they've got muscle loss, but it's not for over. It's not for-[overweight]." (GP4)
2. The dietetic consult experience	
2a. Weight stigma	" …we've had others who've come back and said, "Well what do they know?" and I've said, "Well, they've got all that knowledge and they do know," but they can't get through that barrier of 'she doesn't know because she's really thin' and that's bias. It's perceived bias but it's not a true one because the dietitians are lovely." (GPN2) "So we did have a dietitian that was very, very overweight. That, you could guarantee, every one of my patients would say, "Well you know pot calling kettle black." And I was like, "Yeah, but that's her role to advise you." But that made it difficult." (GPN6) "A lot of the patients who went, came back saying – they fell into very two clear distinct halves – they really liked it, they found it useful, they learnt loads, or they felt they were being judged, and they didn't find it helpful or constructive at all. There was no happy medium. I've always had these two extremes." (GPN9)
2b. Dietitian's interest	"I think mixed experiences, and I think some of that, I think the biggest determinant of that tends to be the interest of the dietitian on obesity because I don't think a lot of them are that interested with obesity. Some are very interested and some are less interested." (GP1) And I sometimes wonder if that's who they saw, when they went to see the dietitian… I think a lot of ours might be general dietitians, and I think if they see our specialist dietitians, they absolutely seem to love them… they get far more out of it. I think they think that the person understands them, and has experience of what they're doing, and what they're going through." (GPN9)
2c. Continuity	"Generally the experience has been poor really. They tend to see people once or twice outside of an obesity clinic and then it doesn't seem to actually make any difference to the weight." (GP1) "…but in terms of the feedback that we get, I don't think it's particularly good here so I don't really know what, you know, I just assume that they maybe just see them once and give them advice and then that's the end of it cause we don't, I don't hear that they keep on repeatedly seeing them and monitoring their weight. I assume it's like a sort of one off intervention rather than a regular thing like a physiotherapist does." (GP5)

Table 3: Illustrative quotes from general practice healthcare professionals regarding their perceptions on the role for a general practice dietitian for obesity management

Themes and Sub-themes	Participant Quotations
1. Utilising dietetic expertise	
1a. Patient contact	"… in the same way that they've really focussed on trying to prevent diabetes before it's really happened, I think we should exactly the same with obesity and to have an in-house dietitian who has the expertise in that area, I think it would make a huge difference… it's actually to have someone who is an expert in that area and giving them the correct advice to help them lose weight and to improve their health." (GP5) "You're much more likely to be on the lookout, scanning for those people, if you know that you've got somebody to go and help. I think sometimes, you don't want to open up that can of worms, when you know there's nothing to help you, once you've done the weight and BMI bit." (GPN8) "I think it would be brilliant. They could enter into the clinical system and use the same system as us, so we can see when they've made an entry, or seen a patient and what the advice is. They'd be a part of our team. They would know the patients like we get to know them. And we'd get to know that member of staff as well. So it would just be a brilliant partnership." (GPN7)
1b. Upskilling peers	"What would be really helpful, is some kind of guidance about how you manage the patients who are not going to fit that criteria, because I'm thinking a majority aren't going to need a dietitian. But then, how do you manage them, because at the moment, I don't think that the guidelines for nursing, well for anybody, are fantastic." (GPN8) "I think that particularly for nurses and healthcare assistants who are often the first port of call for dietetic advice it is better that they get the right advice and at the moment I suspect, well I know some of the stuff that's churned out is questionable… doctors, nurses and healthcare assistants are pretty nutritionally naïve or ill-informed. (GP1)
1c. 'Curbside Consultation'	"So we did, we once had a dietitian back in the day, this is about 20 years ago… who came to the practice and that was a very positive experience… she had a halo effect with other members of staff who could have informal chats with her…"(GP1) "I think having someone to go to and have that conversation about somebody… having that MDT moment with someone, because you may not actually need to refer the patient entirely… And they can say, actually, what we're going to do is, have you thought about this? Have you thought about that? I think it's quite lonely in general practice." (GPN8)
2. Access to dietitian	
2a. Physical access	"We used to have dietitians that used to come into the practice and they did their clinics. And so they were part of the team. And the patients, you could say, they come on a Tuesday and, they're like, Oh Well we know the practice. We know where we've got to come. It's nothing new or scary for them." (GPN6) "If there was a clinic in our practice and we can directly book them in… we'd now know that they'll be seen locally, they don't have to travel. People would be a lot more willing cos they'd see it as part of us rather than a completely separate secondary care thing." (GP7) "… the patients would come in for it, because they wouldn't have to go too far… and it's travel that bothers a lot of them, and lack of buses, and what have you." (GPN9)
2b. Referral pathways	"And we can actually book the appointment there and then… It would make things much more seamless… it would just be ease of doing that referral. Potentially it may just be that I can simply send a task through the SystmOne, the actual patient record." (GPN7) "If it's at the forefront of your mind that you've, you know you've got a dietitian in the building, I might be more inclined to say, oh let me just check your height and weight… then I might then say, oh it might be worth booking an appointment with the dietitian to have a chat. It would encourage me more to actually measure it [BMI] and then knowing that it's an option to just refer someone in the building." (GP5)
3. Time	
3a. Referral to treatment time	"I think the dietitian's role has been quite vital, to that, when they [patients] need the help, they can get the help, at the point of diagnosis, or the point of a crisis, immediate access, rather than saying, well, 'I'll refer you to a dietitian, you'll see them in 4-5 weeks', if we're lucky, by then that window of opportunity has gone." (GPN11) "…it's about setting that commitment, they might make the commitment that day, but by the time they get the appointment six weeks later, they haven't… Again, that's where that time, you know, the time from referring to being seen, the longer it is, the more likely they are to change their mind." (GPN6)
3b. Health professional's time	"I think for me personally from a clinical point of view, it would take a lot of the pressure off me to be able to have to do everything and feel like I'm giving the right advice because things change so frequently as well… but you don't have the time to go through all that [dietary advice], so certainly it would free my time up to look at more things that will suit my skillset more… it would be invaluable really in a lot of ways." (GPN3) "They would take a lot of my work though [laughter]! Because there is quite a lot of dietary advice, even people with high cholesterol levels, do you know, all of that could be incorporated into the role of somebody who was a dietitian." (GPN4) "…basically it would save practice nurse time, that if we found a patient when we're doing chronic disease management, or for anything else, that was willing and wanting to make those changes, we could refer them straightaway, and they could have the follow up, the support that they needed." (GPN10)